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**New Jersey Department of Human Services**

**Division of Developmental Disabilities**

**Support Coordination & Case Management Unit**

**Independent Living Discussion Tool**

Used by the Support Coordinator and planning team to ensure that a safe and supportive plan can be in place prior to an individual moving into an unlicensed setting without a family member/caregiver.

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| **Identifying Information** | |
| Individual’s Name: Click to enter text.  DDD ID #: Click to enter text.  NJCAT Score: Self-Care, Behavioral, Medical  Tier: Choose an item.  Date of Birth: Click to enter text.  Current Program Enrollment:  Choose an item.  Guardianship Status:  Choose an item.  Guardian’s Name if applicable:  Click to enter text. | Date of Meeting: Enter a date.  Purpose of Meeting:  Choose an item.  Current Living Arrangement:  Choose an item.  Will living arrangement be alone or shared?  Choose an item.  If space will be shared, who with?  Enter full name.  Enter relationship. |

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| **Support Coordination Agency Information** | |
| Support Coordination Agency Name: Click to enter text. | |
| Support Coordinator (SC) Name: Click to enter text. | |
| Phone Number: Click to enter text. | Email Address: Click to enter text. |
| Support Coordinator Supervisor (SCS) Name: Click to enter text. | |
| Phone Number: Click to enter text. | Email Address: Click to enter text. |

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| **Supervision and Support Needs** |
| **Need for Personal Guidance** |
| **17.9.4.3.1 Need for Licensure** -  The following factors inform the determination that a setting must be licensed under the provisions set forth in N.J.A.C. 10:44A – Standards for Community Residences for Individuals with Developmental Disabilities: Individuals residing in the setting are on the CCP; – AND – The setting is provider managed (see definition in Section 18.1); – AND – The individual residing in the setting, as documented in the ISP, requires personal guidance as defined in Section 18.1.  **18.1 Definitions**  **Personal Guidance** – the assistance provided to an individual with intellectual/developmental disabilities on a daily basis in activities of daily living because he or she requires help completing such activities of daily living and/or cannot direct someone to complete such activities when physical disabilities prevent self-completion; or there is a documented health or mental health problem requiring supervision of the person for the protection of the individual or others. In the absence of a court determination, the Planning Team determines the need for personal guidance for each individual, in accordance with N.J.A.C. 10:44A-4.3(c)  **Provider Managed** – a setting in which CCP services and supports are coordinated by a singular service provider that manages all aspects of residential services for one or more individual residing in that location. |
| **Self-Preservation** |
| Prerequisites include discussion of and documented evidence that the individual is:   * Capable of self-preservation in emergencies, * Capable of self-administration of medication or can direct assistance, * Self-sufficient with safety at home, including fire safety and minor first aid, * Self-sufficient with personal hygiene, * Capable of telephone use, and * Has basic shopping skills. |

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| **Supervision Needs While at Home** | |
| 1. Where, when, and for how long may the individual be alone while at home?   Click to enter text. | |
| 1. Is there a documented health or mental health problem requiring supervision of the person for the protection of themselves or others? | Yes  No |
| 1. In this new setting, if a primary means of support/supervision is a family member/care giver/SDE, what is the back-up plan if they cannot arrive to provide support?   Click to enter text.  ***(The above information should also be documented in the ISP under Support Settings – Home)*** | |
| 1. Are services that are being identified sufficient to address support needs?   **If No,** additional planning may be needed prior to a move. | Yes  No |

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| **Supervision Needs While in the Community** | |
| 1. Where, when, and for how long may individual be alone while in the community?   Click to enter text. | |
| 1. Is there a documented health or mental health problem requiring supervision of the person for the protection of themselves or others? | Yes  No |
| 1. Can Individual travel independently? | Yes  No |
| **If Yes**, describe the parameters of traveling independently:  Click to enter text. | |
| 1. Is there a history of problematic sexual behaviors, Megan’s Law charges, and/or fire setting behavior? | Yes  No |
| **If Yes**, please explain: Click to enter text. | |
| 1. Is specialized medical care or on site nursing required? | Yes  No |
| **If Yes**, please explain: Click to enter text. | |
| ***(The above information should also be documented in the ISP under Support Settings – Community)*** | |
| 1. Are services that are being identified sufficient to address support needs?   **If no,** additional planning may be needed prior to a move. | Yes  No |

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| **Medication Administration** | |
| 1. Does Individual need help taking medication? | Yes  No |
| **If Yes**, provide a detailed description of the assistance needed: Click to enter text. | |
| ***(The above information should also be documented for each medication in the medication section of the ISP. If independent with a medication, the “Self Medication” column should indicate Yes for each applicable medication.)*** | |
| 1. Are services that are being identified sufficient to address support needs?   **If No,** additional planning may be needed prior to a move. | Yes  No |

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| **Financial Review** | | |
| 1. Does Individual need assistance with finances? | | Yes  No |
| **If Yes**, in what areas? Click to enter text. | | |
| 1. Does the Individual have a Representative Payee? | | Yes  No |
| **If Yes**, who? Click to enter text. | | |
| ***(The above information should also be documented in the ISP under Support Settings – Community)*** | | |
| 1. Can the Individual afford other costs associated with living on own, such as food, utilities, toiletries, household items and furnishings? | | Yes  No |
| **If No,** additional planning may be needed prior to a move. | | |
| 1. If there is concern about potential financial exploitation, has a referral been made to a representative payee program, if they don’t already have one? | N/A  Yes  No | |
| **If No**, please explain: Click to enter text. | | |

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| **Supervision Needs at Mealtime** | |
| 1. Describe assistance needed with meal prep: | |
| Click to enter text. | |
| 1. Describe assistance needed with meal planning: | |
| Click to enter text. | |
| 1. Describe assistance needed with food shopping: | |
| Click to enter text. | |
| 1. Describe assistance needed with eating: | |
| Click to enter text. | |
| ***(The above information should also be documented in the ISP under the Health & Nutrition - Dietary and/or Health Hazards/Concerns.)*** | |
| 1. Are services that are being identified sufficient to address support needs?   **If No,** additional planning may be needed prior to a move. | Yes  No |

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| **Supports and Services Needed in the Proposed Setting** | | | | | |
| ***Ensure that all services (both generic and funded through the budget) are listed to address all support needs.***  ***Each Service requires an entry even if the service is not presently utilized.*** | | | | | |
| **Name of Service** | **Provider** | **Frequency /**  **Duration** | **Funding Source** | **Cost per Plan Year** | **Comment**  ***Required, even if service is not presently utilized.*** |
| Community Based Supports /  Individual Supports | Enter | Enter | Enter | Enter | Choose an item  Comment:  Enter comment |
| Natural Supports | Enter | Enter | Natural /  Generic | N/A | Choose an item  Comment:  Enter comment |
| Self-Directed Employee(s) | Enter | Enter | Enter | Enter | Choose an item  Comment:  Enter comment |
| Day Hab /  Community Inclusion /  Employer | Enter | Enter | Enter | Enter | Choose an item  Comment:  Enter comment |
| Mental Health Services | Enter | Enter | Enter | Enter | Choose an item  Comment:  Enter comment |
| Personal Preference Program (PPP) /  Personal Care Attendant (PCA) | Enter | Enter | Enter | Enter | Choose an item  Comment:  Enter comment |
| Behavioral Supports including CARES, DDHS, Serv | Enter | Enter | Enter | Enter | Choose an item  Comment:  Enter comment |
| Other Services | Enter | Enter | Enter | Enter | Choose an item  Comment:  Enter comment |

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| 1. Total estimated annual cost of identified services: Click to enter text. 2. Total annual budget: Click to enter text. | |
| 1. Does the estimated cost for services fit within the annual budget?   **If No,** additional planning may be needed prior to a move. | Yes  No |
| 1. Are there any barriers to adding necessary services to the ISP? | Yes  No |
| **If Yes**, please describe: Click to enter text.  **If Yes,** additional planning may be needed prior to a move. | |

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| Include any additional, relevant information about this request: |
| Click to enter text. |

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| **Attendance of Planning Team Members** | |
| Name | Title / Relationship |
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**Instructions**

1. Upon completion of meeting, the Support Coordinator uploads the completed form in iRecord.
2. The Support Coordinator makes any necessary revisions to ISP to ensure services are available as discussed by the Planning Team.
3. For assistance or discussion complete a [Seeking Out Support (SOS) Form](https://www.nj.gov/humanservices/ddd/assets/documents/support/Seeking-out-Support-SOS-Form-March-2022.docx), upload in iRecord and contact [DDD.SCHelpdesk@dhs.nj.gov](mailto:DDD.SCHelpdesk@dhs.nj.gov).

**Note:** If the individual presently resides in a licensed setting and they and the Provider wish to have the setting unlicensed, the request from the Residential Provider to un-license the setting must be submitted to the assigned Program Developer.